

Community Based In-Home Services Program & National Family Caregiver Support Program

Monthly Report of Waiting Lists

Please indicate the number of clients that are waiting for services under each category and the reason(s) why. If you have NO clients waiting for services, please show a "0" on the appropriate line.

This form is due to the Aging Division by the 5th working day of each month

Name of Project _____

Report for the month of: _____

	# Personal Care	# Homemaker	# Respite	Total
CBIHS				
Reason(s) * check all reasons that apply	<input type="checkbox"/> funding for services <input type="checkbox"/> worker shortage <input type="checkbox"/> distance to home <input type="checkbox"/> client choice <input type="checkbox"/> _____	<input type="checkbox"/> funding for services <input type="checkbox"/> worker shortage <input type="checkbox"/> distance to home <input type="checkbox"/> client choice <input type="checkbox"/> _____	<input type="checkbox"/> funding for services <input type="checkbox"/> worker shortage <input type="checkbox"/> distance to home <input type="checkbox"/> client choice <input type="checkbox"/> _____	

	# Personal Care	# Homemaker	# Respite	Total
NFCSP				
Reason(s) * check all reasons that apply	<input type="checkbox"/> funding for services <input type="checkbox"/> worker shortage <input type="checkbox"/> distance to home <input type="checkbox"/> client choice <input type="checkbox"/> _____	<input type="checkbox"/> funding for services <input type="checkbox"/> worker shortage <input type="checkbox"/> distance to home <input type="checkbox"/> client choice <input type="checkbox"/> _____	<input type="checkbox"/> funding for services <input type="checkbox"/> worker shortage <input type="checkbox"/> distance to home <input type="checkbox"/> client choice <input type="checkbox"/> _____	

Signature: _____

Date: _____

Please fax this form with a cover sheet to: 307-777-5340 ATTN: Tim Ernst and Kim Latta

